4. Since the Hill-Burton program is administered by the Health Resources Administration, the requested waiver of Hill-Burton charity care requirements cannot be approved by HCFA. The Commission may request a formal ruling from the Health Resources Administration as to whether a hospital may recover from its patient care revenues or other sources of income, the charity care costs it must incur because of the Hill-Burton assistance it received.

5. The MHSCRC will undertake a study of the ESRD treatments provided in Maryland to analyze the effects of the present reimbursement practices on the frequency of treatment, the level of treatment and the per patient maintenance and stabilization costs. MHSCRC will also prepare recommendations on alternative reimbursement systems for ESRD based on the results of the study. A workplan must be submitted to the HCFA project officer for approval by September 1, 1980.

The provisions and restrictions of HCFA Contract No. 600-76-0140 including the CAP formula guaranteeing a limit on Medicaid expenditures shall remain in effect. Any modifications to the Commission's rate setting methodology must be incorporated into the contract.

Medicaid principles of reimbursement shall be waived with respect to hospitals participating in the experiment and receiving payment under the experimental methodology. During their periods of participation, such hospitals shall be paid for services furnished to Medicaid recipients according to experimental payment methodology developed and promulgated by the Commission and approved by the Health Care Financing Administration.

The waivers will be effective for a 3-year period beginning July 1, 1980 and ending June 30, 1983.

Your acceptance of the waivers as described herein is required in writing. If any of these issues require further discussion, please feel free to call on me or my staff.

Sincerely yours,

Earl M. Collier, Jr.
Acting Administrator

MD 9-28-81

11-2-81 7-1-81

DEPARTMENT OF HEALTH & HUMAN SERVICES

The Administrator
Washington, D.C. 20201

RECEIVED
JUL 7 1983
MEDICAL ASSISTANCE
POLICY ADMINISTRATION

28 JUN 1983

RECEIVED
JUN 30 1983
EXEC. DEPT.

a Betty Burke

see Copy attached

The Honorable Harry Hughes
Governor of Maryland
Annapolis, Maryland 21404

Dear Governor Hughes:

Thank you for your letter of April 25, 1983, requesting a continuation of the existing Medicare and Medicaid hospital reimbursement waivers beyond June 30, 1983 for the State of Maryland. As you know, the recently enacted Social Security Amendments of 1983 will permit the Health Care Financing Administration to continue Medicare's participation in State administered hospital reimbursement control systems as a program activity rather than as a special demonstration project. The Maryland program will be the first hospital payment system to be considered for this new program waiver. The necessary regulations to implement section 1886(c) of the Social Security Act are now being drafted and will be issued in August 1983.

To permit the continuous operation of your hospital payment system and to assure a smooth transition to this new program, I am extending your present Medicare and Medicaid demonstration waivers under the authority of section 402 of the Social Security Amendments of 1967 until the regulations are promulgated for section 1886(c) and the State's system has been considered under this section. During this transition period, I have asked both my demonstration and program policy staffs to work very closely with the Maryland Health Services Cost Review Commission to assure that all the requirements of the new legislation are clearly understood.

Several other major changes in Medicare policy have taken place since the award of our previous demonstration waivers. Two significant changes which directly affect the Maryland program are being implemented during this transition period. These are the new Medicare prospective payment rates for dialysis services which are effective August 1, 1983, and the Medicare hospital-based physician requirements which go into full effect on October 1, 1983. We expect these new requirements to go into effect in Maryland when you come under section 1886(c). As a result, we believe it is important for hospitals to begin now making the necessary adjustments to those requirements. Accordingly, I am granting the demonstration waivers for the transition period with conditions that call for the implementation of these new provisions. The full set of conditions to the waivers is enclosed.

The waivers and the enclosed terms and conditions must be accepted in writing within 21 calendar days after the date of this letter by the Executive Director of the Maryland Health Services Cost Review Commission. The Secretary of the Maryland Department of Health and Mental Hygiene must also accept the Medicaid waivers in writing within the same time frame.

Please let me know if I can be of further assistance.

Sincerely yours,

Carolyne K. Davis

Carolyne K. Davis, Ph.D.

Enclosure

TERMS AND CONDITIONS

Medicare and Medicaid Waiver for the Continuation of the Maryland Hospital Prospective Rate Setting Experiment beyond July 1, 1983

1. Medicare and Medicaid principles of reimbursement are to be waived with respect to hospitals participating in the experiment and receiving payment under the experimental methodology. During their periods of participation, such hospitals shall be paid for covered services furnished to Medicare and Medicaid patients according to payment methodologies developed and promulgated by the Health Services Cost Review Commission (HSCRC).

2. Any substantive change in the current rate setting procedures and methodologies of the HSCRC shall be subject to the prior approval of HCFA before its application to Medicare and Medicaid payments.

3. The provisions and restrictions of the present waivers including the CAP formula guaranteeing limits on Medicare and Medicaid expenditures shall remain in effect.

4. The Medicare and Medicaid 6 percent payor differential on HSCRC charges for hospital services rendered to Medicare and Medicaid patients will remain in effect for the duration of this waiver.

5. Medicare payment for services of hospital-based physicians will be made in accordance with the appropriate Medicare regulations implementing section 108 of P.L. 97-248, The Tax Equity and Fiscal Responsibility Act of 1982. The HSCRC should propose to HCFA for approval by August 1, 1983 their plan for implementing this provision including the reasonable compensation test for "Part A" physician services.

6. Medicare payment for outpatient renal dialysis and related physician and laboratory services shall be made in accordance with the appropriate Medicare regulations implementing section 2145 of the Omnibus Budget Reconciliation Act of 1981.

State of Maryland

OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-
TTY FOR DEAF: Balto. Area 383-7555; D.C. Metro 565-0451
Harry Hughes, Governor
Charles R. Buck, Jr., Sc.D. Secretary

July 14, 1983

Carolyne K. Davis, Ph.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Davis:

This letter is to accept on behalf of the Maryland Medical Assistance Program the waiver and enclosed terms and conditions in your letter of June 28, 1983.

It is my understanding that Conditions 1 through 4 continue the existing agreement between the Maryland Health Services Cost Review Commission and the Health Care Financing Administration. Specifically, that agreement includes the provision that Medicaid is eligible for the working capital part of the differential and can take advantage of this feature by making prompt payments or by maintaining a working capital advance according to existing Commission regulations. Medicaid understands that it is free to forego that 2% discount by withdrawing its working capital advance.

While Condition 5 relates to Medicare, it is my belief that the avoidance of double payment for physician services is important for all payors and that equity requires the Commission to apply Condition 5 to all payors. I believe that the plan the Commission will submit to you shortly applies to all payors.

While the Medicaid Program has minimal responsibility for paying for outpatient renal dialysis, I anticipate that Medicaid, as well as the Maryland Kidney Commission and the Maryland Kidney Program - both of which are within

the Department of Health and Mental Hygiene - shall act in such a way as to complement Medicare's policy as reflected in Section 2145 of the Omnibus Budget Reconciliation Act of 1981.

Sincerely,

CRBgm 7/14/83

Charles R. Buck, Sc.D.
Secretary of
Health and Mental Hygiene

CRB/ap

cc: Governor Harry Hughes
Adele Wilzack
Commissioners
Harold A. Cohen

bcc: OS-CRU Official File, fifth floor, O'Conor Building
OS-CRU Reading File, fifth floor, O'Conor Building

CRB/HAC/ap
7/14/83

UNCOMPENSATED CARE PAYMENT METHODOLOGY

The Disproportionate Share Payment Methodology is encompassed in various components of the overall rate-setting system in Maryland. The ongoing process of hospital rate-setting currently consists of four systems: 1) Rate Review; 2) Inflation Adjustment; 3) Guaranteed Inpatient Revenue; and 4) Screening. Hospitals serving a disproportionately large share of poorer patients are recognized and compensated primarily through the Inflation Adjustment System and the Screening System. An integral component of both of these systems is the determination of an appropriate provision for uncompensated care in a hospital's rates. This determination is made on a yearly basis through application of the Uncompensated Care Methodology. It is through the Uncompensated Care Policy, described below, that the additional payment for Disproportionate Share hospitals is accomplished. In the rate review process, a hospital receives a straight markup in all of its approved unit rates for uncompensated care. For example, assume Hospital A has the following set of approved rates:

Revenue Center A: $350.00

Revenue Center B: $100.00

Revenue Center C: $ 80.00

Assume further that Hospital A's bad debt and charity care experience is approved at 3% of total revenue. Hospital A is allowed to charge the unit rate established in its revenue centers plus 3 percent for uncompensated care. Thus, the approved rates become:

Revenue Center A: $350.00 + 3% = $360.50

Revenue Center B: $100.00 + 3% = $103.00

Revenue Center C: $ 80.00 + 3% = $ 82.40

If Hospital A's mix of patients changed during the year and altered its uncompensated care factor, then the change would be incorporated in the rate adjustments for inflation. The Inflation Adjustment System constitutes the setting where a hospital's uncompensated care experience is evaluated on a yearly basis and accounted for in rates. For example, if a hospital treated a greater number of patients unable to pay for their care this year than last year, then the corresponding increase in costs to the hospital would be reflected in the bad debt factor, and the hospital is compensated for those additional costs through a rate adjustment.

Inspection of the regression equation immediately reveals that a hospital with a high disproportionate share factor will benefit, in that its regression-adjusted average cost is increased, thereby lessening a positive and widening a negative difference between actual and regression-adjusted cost. As an example, consider the following scenario for fictitious Hospital A:

ACOST	=	$3970
CMACOST	=	$3970
DISP	=	.4300
RESBED	=	.0900
b_1	=	.20000
b_2	=	.42000

The Uncompensated Care Methodology is the process by which the Maryland rate-setting system recognizes bad debt and charity care as a part of a hospital's full financial requirements. As with all other components of the Health Services Cost Review

Commission's ("HSCRC") rate setting system, the uncompensated care provision is subject to a reasonableness standard based on a regression analysis. The regression analysis produces a predicted level of bad debt for each hospital, which serves as the ceiling for the uncompensated care provision in rates. The estimating equation is reviewed annually and, as a result, the explanatory variables may change as better measures of predictors are developed. One variable that has consistently been a highly significant predictor of a hospital's level of uncompensated care is the percentage of revenue attributed to Medicaid patients.

The actual level of uncompensated care included in rates is based upon an analysis of the predicted amount, the actual amount incurred by the hospital, and the amount in rates. Also considered in determination of a hospital's level of bad debt in rates are the relative profitability of the institution, and its relative standing in charge per admission. The Uncompensated Care Methodology is explained in greater detail in the following paragraphs.

The Uncompensated Care Methodology can be divided into three parts: First, a regression equation is estimated using the most current statewide data. The most recent uncompensated care regression used Fiscal Year 1989 data and was adopted by the HSCRC at its June 1990 public meeting.

The uncompensated care empirical model is a single equation model where the amount of actual uncompensated care as a percentage of gross patient revenue is hypothesized to be linearly dependent upon the following variables:

MCAIDSSI = the percentage of gross revenue attributed to Medicaid and Medicare SSI patients

PIPCOMM = the percentage of inpatient revenue from commercial payors

URBAN = the percentage of revenue for patients originating from Baltimore City and District of Columbia zip code areas and

EMGNMCAR = the percentage of revenue of non-Medicare patients admitted to the emergency room

The specific form of the estimating equation is :

BDCHARD3 = $b_0 + b_1 * MCAIDSSI + b_2 * PIPCOMM + b_3 * URBAN + b_4 * EMGNMCAR$

where BDCHARD3 = percentage of gross patient revenue for uncompensated care less Medicaid state only day limit. BDCHARD3 is calculated as follows:

BDCHARD3 = (BDCHARD2 - (STATE 89/1000/(RELE - RDLOUT))).

In the above equation, BDCHARD2 is calculated based on a hospital's RE Schedule and represents a hospital's actual uncompensated care as a percent of gross patient revenue. STATE 89 is the Medical Assistance Program's estimate of revenue effect of State only day limits. RELE is total gross revenue/1,000 as reported on RE Schedule and RDLOUT is outpatient renal dialysis revenue/1000.

The creation of MCAIDSSI warrants some explanation. MCAIDSSI is the percentage of gross revenue attributed to Medicaid plus Medicare patients who are SSI eligible. The percentage of Medicaid revenue is derived from a hospital's PDA Schedule. The SSI information is developed using a three-step process. First, the total number of patient days for Medicare patients who are SSI eligible was obtained from Medicare fiscal interm[illegible]